Economics

The HSO experiment: better than fee-for-service?

EVELYNE MICHAELS

An experiment is taking place in Ontario which could revolutionize the delivery of medical services across Canada — or fail after a decade of trying.

Under the microscope is the Health Service Organization (HSO) system, a scheme which has drawn varying amounts of praise and blame from those interested in the philosophy and economics of health care.

What exactly is an HSO? On the surface it appears much like any other clinic or medical practice, with patients coming and going, receiving services from a variety of health professionals. But what distinguishes the HSO from the average clinic is how those patients pay the bill or, more specifically, how the government pays for the services that patients receive.

There are two basic funding models for HSOs in Ontario. In the *global* or budgeted system, the clinic (which is officially termed a CHC or community health centre) receives a monthly lump payment based on an approved number of physicians and nurses employed at the clinic. This is an interim arrangement to let the centre develop a roster of clients and graduate to the second model, the capitation system.

Under *capitation* the clinic receives a monthly payment for each rostered patient who holds valid health insurance. The rostered patient has signed a form agreeing to receive all his or her primary medical care at the HSO clinic. The contract is an informal one, and while the client cannot be penalized for going to another doctor, the system *can* penalize the HSO financially if that client goes elsewhere. The capitation rate is determined by the previous year's fee schedule under the Ontario Health Insurance Plan (OHIP).

The definition becomes even more complicated by the various types of HSO sponsorship. In the *community-based model* the clinic is a nonprofit corporation or association controlled by a board of trustees which is elected by the roster members and the community. In the *provider model* the clinic is owned and operated by a doctor who employs other doctors and staff. In the *private corporation model* the clinic is owned and operated by a corporation which employs physicians and other staff.

There are now some 30 HSOs and community health centres in Ontario, and this year they formed a provincial association of their own. Dennise Albrecht says the centres are like snowflakes — similar but different and very fragile.

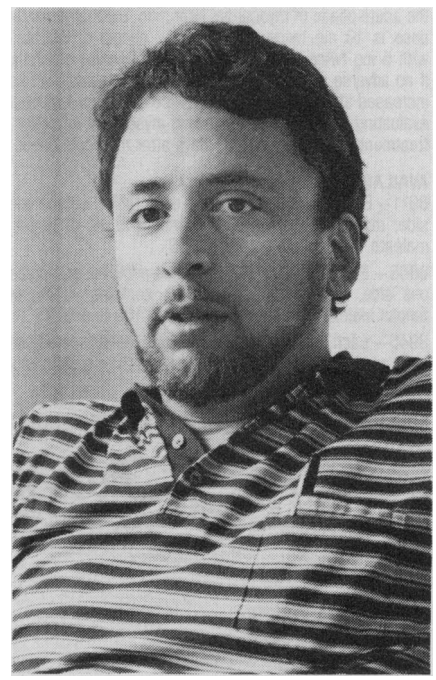
Albrecht is executive director of the Sandy Hill Community Health Centre in Ottawa, a clinic which is currently struggling to sign up enough clients to gain capitation status. As of March 1982, Sandy Hill had 4274 patients registered but only 800 signed. The centre would need about 4500 signed, rostered patients in order to qualify for capitation funding. The clinic offers the services of two full-time doctors, two nurse practitioners and a part-time social worker and nutritionist.

What are the benefits of the HSO system over the traditional fee-for-service structure which exists in most of Canada? Apparently, it depends on whom you ask.

Dr. Bill Seidelman is the director of services in the department of family medicine at McMaster University, which operates one of the largest HSOs in the province — four family practice units serving a patient population of 16 000. According to Dr. Seidelman, the overall goal of the HSO is "to enable physicians to broaden the scope of primary and community health service which, it is hoped, will result in a reduction of hospital utilization". (To this end the current HSO system offers a potential supplement based on hospital days saved. If an HSO patient is hospitalized for fewer days than the district average, the HSO will receive a third of the potential hospital costs saved.)

Ideally the HSO aims to provide the same primary health care as the traditional clinic, but there is emphasis on preventive care, health education and maintenance, self care and home care.

Dr. Seidelman says that the HSO



Seidelman: "pluralism and competition in health care delivery".

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mechanism allows the doctor to organize his or her practice "in a way that allows [them] to focus their skills on those patients needing more attention". The physician can use the services of other health professionals in the practice without being financially penalized for not actually performing the service the patient receives.

Dennise Albrecht of the Sandy Hill centre believes the HSO is an attractive alternative to the current fee-for-service system from all angles. For the government, it may be a way to head off runaway health care costs. "The provincial government didn't go into this in an altruistic fashion", she says. "A doctor may not see each patient more cheaply than in the fee system, but studies seem to indicate that HSO patients use hospitals less often and for a shorter time." Certainly the incentive to have patients come in more often does not exist in the HSO system because the doctor's salary is not tied to the number of services rendered.

Next year the HSO program in Ontario will be 10 years old and the provincial government is currently pondering the fate of the system.

In an interview with *CMAJ* Health Minister Larry Grossman revealed that the ministry is about to "fish or cut bait" on the HSO program. "So far the HSOs have been existing on a 'sort-of' basis", says Grossman. "If they are going to remain, I believe they deserve to be taken off this trial basis and relieved of the constant worry over whether they are going to be in business next year."

Grossman would not say if this means the program will be expanded or dropped altogether. That announcement will be made sometime this fall after a ministry review. But he did say he believes there is room in the health care system for alternative funding modes like the HSOs. "I can't believe that in a system which has 14 000 doctors, 230 public hospitals and thousands of health care professionals, no room exists for an HSO concept. But", Grossman warns, "there is no room for things that are inefficient, expensive and are using up health dollars that could be better spent."

The government's review of the HSO experiment may be based on more than just economic prudence, however. Dennise Albrecht of the Sandy Hill centre says that while doctors have not organized a "blatant resistance" to the HSO idea, "over the years we have had the sense that there's not a lot of support from the OMA [Ontario Medical Association] for the concept of the salaried physician. I don't know why."

Dr. Bill Seidelman of McMaster University agrees that the introduction of the capitation funding scheme has made many doctors uncomfortable. "They see it as the thin edge of the wedge of a larger national health service system", he explains.

But Dr. Jack Saunders, director of health services for the OMA, says most doctors don't question the right of their colleagues to opt for salaried status through HSO practice. "We're not dead against them", he says, "but we wonder if these clinics are really providing better or cheaper care."

Dr. Saunders says many doctors do have reservations about HSOs because the system is run by the government. "They are too much involved in health care as it is and so anything which increases that involvement is going to be viewed by doctors with a jaundiced eye."

Grossman: "fish or cut bait".

The fee-for-service system is still the best way to provide medical service and stay close to each patient, according to the OMA, which has often worried aloud about the physician's growing loss of independence in a system where the government dictates the delivery of health services.

Dr. Saunders also questions the practicality of a more general HSO scheme. Because physicians working in an HSO see fewer patients, reasons Dr. Saunders, the system would require 25% more doctors to serve the same patient population — and thus any savings would be negated.

While many doctors may fear that the HSO model will erode their independence and threaten the fee-for-service status quo, others, like Dr. Bill Seidelman, are convinced that the HSO is good medicine. "The doctors who work at HSOs and health centres are committed

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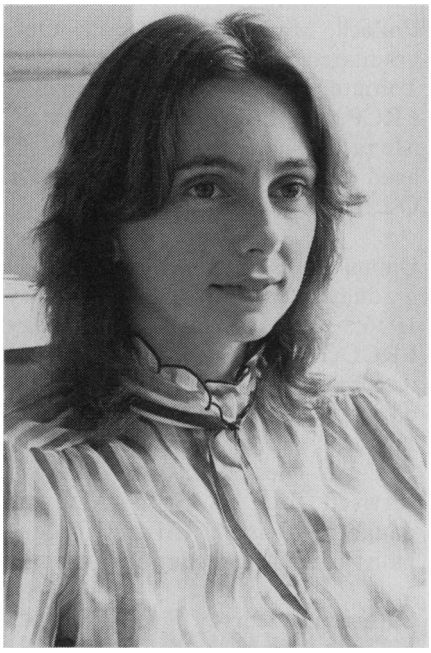

Albrecht: our doctors have different values.

practitioners who feel the HSO system allows them to focus their care on patients who need it the most", he says.

"Our doctors seem to have a different set of values", says Dennise Albrecht. "They're younger, they tend to be women, and they're interested in alternative medicine within a team setting."

Very few people dispute the quality of the health care dispensed by the HSOs. But are they the wave of the future or just an interesting experiment dreamed up by a group of civil service economists and idealistic doctors? Dr. Seidelman believes the system is, for the most part, doing well, but he admits that the idea of converting the whole medicare system to capitation funding is "a pipe dream. These centres introduce an element of pluralism and competition into the system of delivering primary health care services", he says.

So far the biggest achievement of the HSO is an apparent reduction in hospital utilization among roster members — an outcome already noted and documented in the United States which has a similar system.

But the road to capitation is not without certain hazards. The current system places an enormous administrative strain on the HSO practitioner and administrative staff who must try to communicate with an OHIP system not geared to their needs.

Dennise Albrecht of Sandy Hill says there are lots of logistic problems. "For example, a female patient can be on our roster. Then she gets married and is covered under her husband's OHIP. Our number for her becomes invalid and because the OHIP computer can't talk to the HSO computer, it becomes very confusing. A misspelled name can be a disaster."

If the HSOs are to flourish — or at least survive — in Ontario, they can't do it alone. First the provincial government will have to risk the wrath of more conservative physicians and give the HSO full-fledged rather than "maybe" status. Then the system will have to be refined and improved. In the end, the outcome of this particular experiment may be balanced more on politics than on science.■

CMAJ retrospect

"With community health centres, the doctor has a viable alternative," said the Minister [Hon. John Munro]. "He can ask himself: 'Does this patient need to be hospitalized?' If the answer is no, then the community health centre provides facilities for the treatment. The hospital and the centre become complementary parts of a total comprehensive health services delivery system."

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